Mr Kevin Martin

The Radcliffe

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection of The Radcliffe took place on 24 and 26 November 2015 and was unannounced. The previous inspection had taken place on 5 November 2013. The service was not in breach of the health and social care regulations at that time.

The Radcliffe is registered to provide personal care and accommodation for up to 34 older people; some of whom are living with dementia. The home is made up of two buildings, connected by a covered walkway. One building has 17 en-suite bedrooms and the other building has 17 bedrooms; of which five are en-suite. The home has three communal lounges, two communal dining areas, five communal bathrooms and an enclosed garden and outdoor seating area.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

People told us they felt safe and staff had received training in relation to safeguarding vulnerable adults.

Risk assessments were in place to help reduce risks to people.

Appropriate health and safety checks were completed regularly, in order to help keep people safe. However, there were no emergency procedures in place to keep people safe in the event of a major incident or emergency situation. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had some concerns regarding the way in which medicines were administered. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's consent to care was sought. Where people lacked capacity to make specific decisions, a mental capacity assessment had been undertaken and decisions were made in people's best interest. Where people were deprived of their liberty, authorisation had been granted by the local authority.

The environment was not always conducive for people living with dementia.

People and their families told us staff were caring. We observed staff being caring and respectful to people. People were supported to practise their faith.

Although the care plans we looked at were person centred, we found they were sometimes lacking in information and some contained contradictory information.

There was an activities coordinator and we saw people had a range of activities to choose from. People told us they felt they had choices.

Some policies and procedures were in need of updating.

The registered manager had identified some areas for improvement and had developed an action plan with a view to making improvements at the home. However, there were other areas which required improvement that the registered manager had not recognised prior to our inspection. This was a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People told us they felt safe.

Risk assessments were in place to help keep people safe.

No emergency procedures had been developed, to help keep people safe in the event of an emergency situation.

Improvements were required to ensure safety in relation to medication administration.

Requires improvement

Is the service effective?
The service was not always effective.

Relatives told us staff understood people's needs.

People were given support to ensure their diet and nutritional needs were met.

Some staff had not received training in relation to the Mental Capacity Act 2005.

Staff had not received regular supervision.

Requires improvement

Is the service caring?
The service was caring.

People and relatives told us staff were caring.

We observed positive and caring interactions between staff and people.

People's end of life wishes were considered and respected.

Good

Is the service responsive?
The service was not always responsive.

There was a range of activities for people to participate in.

People told us they felt they had choices.

Care plans were personalised but some lacked detail and contained contradictory information.

Requires improvement

Is the service well-led?
The service was not always well led.

Some policies and procedures were in need of updating.

Requires improvement

Summary of findings

Regular audits took place but it was difficult to determine whether actions had resulted because records were incomplete and our findings showed that some areas of concern had not been addressed by the management of the service.

The registered manager had developed an action plan to drive some improvements at the home but this had not addressed some areas which were identified at the inspection.

The Radcliffe

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 24 and 26 November 2015 and was unannounced on both days. The inspection was carried out by two adult social care inspectors. Before the inspection we reviewed the information we held about the home and we gathered information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The registered provider had been asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was also used to assist with the planning of our inspection and to inform our judgements about the service.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with seven people who lived at the home, three visiting relatives, four care staff, a cook and the registered manager.

We looked at six people's care records, six staff files and training data, as well as records relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and other communal areas.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe. One person told us, "Oh yes, I feel safe." Relatives we spoke with also told us they felt their family members were safe living at the home.

The registered manager had completed safeguarding training with the local authority and we found they had a clear understanding of what constituted abuse and the signs to look for which may indicate abuse. The registered manager was clear about the procedures they would follow if they suspected anyone was being abused or was at risk of harm. Staff had been issued with information regarding safeguarding, advising them of what signs to look for and what actions to take if they suspected anyone was at risk of being abused. The staff we spoke with showed they understood these. This showed that steps had been taken to prevent abuse and improper treatment.

We found that risk assessments were in place. For example, falls risk assessments took into account different factors regarding a person's needs, mobility and history and this resulted in a score. Depending on the number of the score, the person was indicated as low risk, medium risk or at risk. For each indicator there was then a description of actions to take. Attached to some, but not all, people's risk assessments were 'achievement plans.' These detailed what the person was hoping to achieve, how it would be achieved and what would happen should the plan fail. This showed that people were encouraged to be as independent as possible, whilst taking steps to minimise risks.

The registered manager had subscribed to the principles of the Herbert Protocol. The Herbert Protocol is a national scheme which encourages carers to compile useful information which could be used in the event of a vulnerable person going missing. The Herbert Protocol puts systems in place to allow for early intervention when vulnerable people go missing. This demonstrated the registered manager had procedures in place to help keep people safe.

We saw evidence that weekly safety checks were undertaken, such as fire alarm testing and emergency lights and hot water temperatures for example. Gas safety had been tested during August 2015 and Portable Appliance Testing (PAT) had taken place during April 2015.

The lift was regularly maintained. We found the maintenance file to be well organised, with a clear indication of the 'next due date.' This helped to ensure the premises were kept safe.

We asked the registered manager if there were emergency procedures in place in the event of emergencies such as evacuation, lift breaking down, gas leak or loss of power for example. We were told these situations would be dealt with, "as and when." We raised our concerns regarding this with the registered manager and, on the second day of the inspection, the registered manager had begun to develop some emergency procedures and shared these with us. It is important that registered providers are able to respond to major incidents and emergency situations to ensure that people are safe and any risks are minimised. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.

We saw that accidents and incidents were recorded on an accident record. However, the section on the accident form entitled, 'Action taken to prevent reoccurrence – recommendations' was not completed on any of the 11 incident records which we looked at in relation to one person. We highlighted this concern to the registered manager, who was able to show us evidence that the accidents had been analysed and action had been taken. However, this was not evident on the individual records. It was therefore difficult to determine, from the records, what action had been taken following each individual incident.

Accidents and incidents were analysed in an attempt to identify any trends. We saw that action had been taken, for example referrals made to a falls clinic or medication reviews following accidents. We saw that appropriate observations were made following falls incidents. Additionally, the registered manager had identified that some falls pressure mats, which were intended to alert staff if a person awoke and moved around during the night, could potentially cause falls because they were a shiny surface and some people chose to wear socks at night, which could cause them to slip. Therefore the registered manager was in the process of exploring alternative solutions. However, the risk was still present and the registered manager had therefore ensured regular checks were made on people.

Requires improvement

Is the service safe?

We looked at three staff files and found that safe recruitment practices had been followed. For example, the registered manager ensured that references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

There was a mixed response regarding whether staffing levels were adequate. A member of staff told us that, "It can be manic." However they also said that an additional member of staff had recently been deployed and this had a positive impact. One member of staff we spoke with told us they felt there were enough staff to meet people's needs. A family member we spoke with said, "You can always see someone [staff]. They get there quickly enough." People we spoke with told us they felt they did not have to wait, "Too long," for assistance from staff. We spoke with the registered manager regarding staffing levels. The registered manager told us they used their experience and took into consideration people's mobility, nutritional support needs and behavioural factors for example. We found the numbers of staff identified as being required were deployed.

Although no staff had been disciplined, the service had a clear staff disciplinary policy which the registered manager outlined to us. Furthermore, the service subscribed to an employment law advisory service. This meant that clear processes were in place in order for action to be taken if staff performance or conduct fell below that which was expected.

We looked at whether medicines were managed and administered appropriately and safely. Staff had received specific training in the safe administration of medicines. In addition to this, we also saw evidence that competency tests had taken place using a 'Medicines with Respect' tool. This provided an assessment framework for administration competence.

We saw the person administering medicines was wearing a tabard so it was clear they should not be interrupted or disturbed. Medicines were stored securely and were dispensed from packs which indicated dates and times for medicines to be administered. We saw the member of staff prepared the medicines for three different people into separate pots and these were placed on a tray. The staff member was then disturbed because someone needed assistance. Although the staff member placed the three medicine pots securely inside the medicine trolley, this meant there was a risk that people could be given the wrong medicine. It would be good practice to prepare and administer one set of medicines at a time and to ensure the staff member administering medicines is not disturbed, in order to reduce the risk of people receiving incorrect medicines. We highlighted this to the staff member at the time and to the registered manager.

We observed one person to be given medicine in the form of a large tablet. They started to cough and staff responded to this quickly, offering the person some water and reassurance. We checked this person's care plan and saw they had been assessed as requiring a soft diet. We raised this with the registered manager and registered provider and advised they requested a review of the person's medication, because this meant the care being provided to the person was not in line with their care plan and therefore may not be safe. Following the inspection the registered provider confirmed to us that the person's medication had been reviewed with their GP and no changes were necessary.

Some people were prescribed creams that were to be applied to their skin. We found the recording and storage of creams to be inconsistent. For example, the medication administration record (MAR) stated that creams were kept in people's rooms. However, we found that one person's cream was kept in the locked trolley. We found cream had been opened but no date of opening had been recorded. This could mean that staff would not know when the cream expired. The time that creams were applied to a person's skin were also not recorded. Additionally, body maps were not kept with the creams, so it would be difficult for staff to determine exactly where on the body to apply the cream. This could mean that medicinal creams were not appropriately applied.

Some medication was PRN (to be given as and when required). In relation to this type of medicine, the registered provider's policy stated, 'Information on why and when medication is to be taken should be obtained from the prescriber; it is not acceptable for instruction to be only 'as required' and this should be recorded in the individual's care plan and on the MAR chart.' We noted that a person was given a PRN medicine when they were agitated. The person's care plan stated, 'For use should [name] portray

Requires improvement

Is the service safe?

unsettled periods.' There was no indication of the signs that staff should look for or in what specific circumstances this medicine should be given. This meant the person could be at risk of being administered medicine inappropriately.

The accumulation of our concerns in relation to the administration and recording of medicines demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the registered provider did not ensure the proper and safe management of medicines and staff did not follow policies and procedures about managing medicines.

We checked the controlled drugs, which are prescription medicines that are controlled under Misuse of Drugs legislation. These were stored securely and we saw that, whenever these were administered, two members of staff checked the remaining amounts and signed. This showed that controlled medicines were being properly controlled.

We observed that care staff carried a small container of hand sanitiser clipped to their uniform and we saw staff use this. We observed staff wash their hands and we also saw staff wearing Personal Protective Equipment (PPE) when assisting people, such as gloves and aprons. This helped to prevent and control the spread of infection.

Requires improvement

Is the service effective?

Our findings

A person we spoke with said, in relation to the home, "It's the best place I've been to." A relative we spoke with said, "Staff know what they're doing. They understand [name]'s needs. There are rarely any problems."

Comments from a recent consumer survey, from a visiting professional, stated, 'In my profession, I regularly communicate with staff regarding patients and always get a satisfactory response.'

The staff we spoke with told us they felt they received appropriate training to enable them to support people. We looked at staff training records and the training matrix. This showed that staff had received up to date training in areas such as fire safety, health and safety, medical emergencies, moving and handing, safeguarding and first aid for example. Newer staff members told us they had the opportunity to shadow more experienced members of staff, and we saw they had received an induction, before commencing their caring duties. This meant that staff had received essential training and information, prior to commencing their role.

Staff had undergone experiential learning in relation to moving and handling. This gave members of staff the opportunity to experience what it was like to be assisted to move with the use of a hoist for example. This offered staff a better understanding of the needs of people they were supporting.

Staff training was supplemented by additional learning through a television training network which the registered provider had subscribed to. We saw some staff had utilised this method of training in areas such as everyday care, night time care and understanding dementia. This style of training was designed to use storytelling in order to engage, inform and inspire staff with their learning.

The registered manager told us they were working towards staff receiving supervision every six months and an annual appraisal. We were concerned at the frequency of this and were told that staff were able to approach the registered manager if they had any issues to discuss. Staff confirmed they felt able to approach the registered manager. However, this meant there was a risk that competence was not maintained because appropriate ongoing or periodic supervision was lacking.

The home's website stated that one of the home's objectives was for, 'people living with dementia to have a good experience of care.' We asked the registered manager if they had researched or sought best practice guidelines in relation to dementia care. We were told that no best practice guidelines were followed and that the registered manager had years of experience. We highlighted to the registered manager and registered provider that it is important to read and implement nationally recognised guidance and to be aware that quality and safety standards change over time.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager had received MCA and Deprivation of Liberty Safeguards (DoLS) training from the local authority and told us that senior staff had received training in this area from the operations manager. We noted, however, that only eight out of 37 members of staff had completed training in MCA and DoLS. We asked the registered manager about this, who was able to show us that this was highlighted on their action plan, but there was no timescale as to when staff would receive the training. Although the majority of care staff had not received training in this area, the staff we spoke with had a good understanding of MCA and DoLS.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

People's consent to care was sought. The registered manager had a good understanding of the principles of the Mental Capacity Act and of how decisions might be made in a person's best interest if they lacked capacity. Mental capacity assessments had been completed for people where it was felt they may lack capacity to consent to care and treatment for example. Where people did lack

Requires improvement

Is the service effective?

capacity, we saw evidence that decisions were made in their best interest. These decisions took into account the person's history, the views of the person, their relatives or representatives.

The registered manager had appropriately sought advice from the local authority and authorisation had been granted for people who were deprived of their liberty. The registered manager had kept a record of any DoLS applications, their outcome, whether they were authorised and the expiry date. This meant that new applications could be made when necessary.

The registered manager told us that menu planning was discussed with people who lived at the home, although we did not see evidence of this. People told us they had a choice of what they wanted eat and we saw there were two choices of available dishes at lunchtime and teatime.

We observed a lunch time experience. The tables were laid with tablecloths, flowers, cutlery and serviettes. The food looked and smelled appetising. We heard positive comments from people regarding the food. One person said, "It's beautiful and hot. It's very nice. The vegetables are lovely." People received appropriate support to eat their meals and were asked if they would like more. We saw some people were discreetly encouraged to eat more. This helped to ensure that people had their diet and nutritional needs met.

We saw that, where people were nutritionally at risk, referrals had been made to the dietician and the speech and language therapy team and people were weighed regularly. The cook was aware of any specific dietary requirements. The registered manager told us that people were encouraged to maintain a healthy lifestyle with the involvement of the activities coordinator such as by walking and participating in gentle exercises.

People had access to health care and we saw that referrals were made to other agencies or professionals. For example, we saw in people's records they had been referred to a chiropodist, optician and district nurse for example.

We noted that the physical environment within the home was not always conducive for people living with dementia or with impaired senses. Signage and labelling was lacking; for example some toilet doors had a room number on the door so there was no indication that it was a bathroom. The carpet in the stairs and landing area on one side of the home was heavily patterned and, although handrails were in place, this could make it difficult for anyone who was visually impaired. There was a lack of pictorial signage which could help people to navigate around the home. We asked the registered manager about this and they told us they were mindful there were some people living in the home that did not have dementia and it may not be suitable for those people. We highlighted the importance of researching effective care environments to the registered manager.

Good

Is the service caring?

Our findings

One person we spoke with said, “Staff are nice. It’s okay here but it just takes some getting used to. I get my paper every day.” Another person told us, “Staff are pretty much one of the same. They aren’t so bad. They’re pretty good.” Another said, “The staff? I can’t fault them.” A family member told us that the home was, “Home Sweet Home.”

A compliment log included a comment, “[name] said staff were wonderful and they couldn’t be better cared for anywhere.”

Comments in a recent consumer survey, from a visiting professional, stated, ‘Nice, clean, homely, very friendly staff. Manager’s friendly and helpful.’ Another comment said, ‘privacy is being maintained.’

The registered manager told us they tried to lead by example and they observed staff regularly, ‘on the floor’ to ensure that staff were caring in their approach. We saw the registered manager assisting a person to their seat. The registered manager was moving at the person’s pace. Words of reassurance and appropriate prompts were offered to the person. For example, the registered manager said, “turn to your left now. Feel for the chair. You’re safe now here.” The interaction was of a caring nature.

We witnessed some instances where people were being assisted to move. We saw that staff were caring and offered reassurance to people as they were assisted. For example, staff said to the person, “The hoist’s in front of you now. It’s going up now [name].”

When people were sat in dining chairs, awaiting lunch to be served, one member of staff observed that a person looked to be uncomfortably seated. The staff member approached the person and discreetly asked if they wanted assistance to move, in order to be more comfortable. This demonstrated kindness and compassion.

At lunchtime we observed people being asked in a respectful manner whether they would like a napkin or whether they would like to wear a clothing protector. We saw a carer, who was assisting a person to eat their meal, remind the person what was on the plate and the person was asked if they would like some salt. We saw another staff member ask a person if the temperature of the meal felt okay, as they were assisting the person to eat.

Staff told us they maintained people’s privacy and dignity by always knocking before entering rooms and closing curtains when appropriate. However, we did observe a member of staff knock on a door, after they had opened it.

Consideration was given to people’s identity and people were given the care and support they needed to practise their faith. Leaders from different faiths visited the home regularly. Staff ensured that, whilst some people were practising their own faith, others were supported in other activities.

People were able to keep their possessions secure and have their privacy in their rooms if they wished. One person told us they had a key to their room and it was lockable. We saw in another person’s care file that they had been asked but had declined to have a key.

There was evidence that people’s end of life wishes where taken into account. We saw that some people had up to date Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in their files. A separate record was also kept of these so the registered manager could identify who had them in place. A number of staff we spoke with told us they were currently completing some end of life care training.

Requires improvement

Is the service responsive?

Our findings

One person we spoke with told us, "[name] takes us out for a walk, by the water. They do look after us." A visiting relative we spoke with told us, "There are more activities than there used to be," and, "I can visit [name] whenever I want," and, "I'm involved in the care plan."

We saw that people's rooms were personalised and contained sentimental items pertaining to the individual. Rooms were clean and airy. We saw that call bells were within reach so that people could summons assistance if required.

We saw care plans that were person centred, although we found the information contained within the plans was sometimes difficult to navigate. Some care plans were not kept in the same building where the person was being cared for, as they were in the main office. This could mean that relevant care staff did not have access to important information. We raised this with the registered manager who explained they had considered this but felt it was important to have the care plans in the office because, for example if health care professionals made contact, staff would need access to important medical information contained within the care plans. The registered manager had tried to overcome this problem by duplicating some of the information so that it was available to relevant care staff.

Care plans contained important personal information such as the person's likes and dislikes, their life history and family details for example. The support people required was detailed in areas such as mobility, personal hygiene, food and nutrition, continence needs, night care needs and communication needs for example. The person's individual needs were documented in each of the areas.

We found that some care plans were detailed and gave staff a clear indication of the support a person required. For example, one plan stated, 'Let [name] know who you are'. We observed staff to do this as they approached the person. However, some plans lacked detail and sufficient information. For example, one care plan stated, in relation to a person displaying repetitive behaviour, 'Use distraction techniques,' but the plan did not state what distraction techniques would be effective or how they should be used to support the person. Another plan stated, 'Should [name] be unable to weight bear then the patient hoist or stand aid may be used.' However, there was no guidance as to how to determine this and how to assist the person to move. We highlighted this to the registered manager and registered provider.

A care plan we looked at contained contradictory information. The plan stated the person, 'requires soft liquidised diet.' However, the nutrition section of the plan stated, 'provide 2-3 nourishing snacks including fruit cake, crisps, nuts, crackers, sausage rolls.' The staff we spoke with were aware of the person's dietary needs but this could mean the person may not receive appropriate care and support according to their need. We raised this with the registered manager and registered provider and they agreed to address this.

Within the care files we saw a letter dated April 2015, requesting family members to complete a customer survey. We also saw letters to family members inviting them to be involved in care planning for their relative, although these letters were not dated. In one care file we looked at we saw evidence of a meeting held with the person, their family and a social worker to review the person's care. We saw that care plans were evaluated monthly. This helped to ensure people were receiving the support they needed, according to the person's current needs.

The home employed a dedicated activities coordinator. This meant that care staff at the home were able to continue to provide care whilst people participated in activities. We saw that activities had been organised for 25 days out of the 31 days of the month of the inspection. Activities included singing, indoor games, keep fit, bridge, arts and crafts and quizzes for example. One person, who had a keen interest in gardening, had been involved in developing the garden area outside of the main door. This showed that people engaged in activities that were meaningful to them.

The registered manager told us that family and friends could visit people at the home at any time and they were encouraged to stay and share a mealtime experience. A family member we spoke with confirmed this.

We were told by the registered manager that people had choice. For example, people could choose when to rise and when to retire to bed, what to eat and drink and when they would like to bathe for example. This was also highlighted in people's care plans. For example, one care plan stated

Requires improvement

Is the service responsive?

the person, 'Would like to choose what [name] wears on a daily basis.' People confirmed to us they felt they had choice. We saw people were offered a choice of meals and drinks at lunch time.

One person told us they preferred to stay in their own room during the day. They told us they had plenty to eat and drink and that staff came to check on them regularly. We noted this person had access to their call bell. They told us they used the buzzer if they needed assistance and said, "it's not too bad a wait." This person told us they felt listened to.

Information was made available and was on display advising people of what to do if they wanted to make a complaint. We looked at how the registered manager dealt with complaints. We looked at the complaints file and saw there was a complaints procedure, detailing how complaints would be dealt with. We found that the complaints received had been responded to in line with the policy and complainants were kept informed of progress and actions taken.

Appropriate information was shared between staff at the commencement of each new shift. This took place during a staff handover. Staff handover sheets included information relating to people's mobility needs, diet and fluid intake and mood and wellbeing for example. This meant that important information was shared between staff so that people received appropriate care and support.

Requires improvement

Is the service well-led?

Our findings

The home had a registered manager in post, who had been managing the home since June 2015 and who had registered with the Care Quality Commission to manage the home since August 2015.

A member of staff told us the registered manager and registered provider were approachable and visible throughout the home. We were told by staff that the registered manager would give direction but was not, "Hands on."

We saw the registered manager had due regard for the duty of candour, which meant they acted in a transparent way. The most recent inspection rating and report were displayed and shared on the noticeboard for anyone who wished to see it. We found the registered manager to be honest and open with us during our inspection and they were responsive to issues we raised.

The registered manager told us they felt supported by the registered provider and the operations manager. The registered provider was present at the home most days and showed an interest in the running of the home. A member of staff told us the registered provider was, "friendly" and, "knows the residents." The registered manager held regular meetings with the registered provider and shared information, for example in relation to the environment, complaints, staffing and people's care needs.

The home had links with the wider community. For example, on one of the days we inspected, representatives from a local place of worship were holding a service at the home. Other community groups had been invited to the home to sing Christmas Carols. Some people who lived at the home were supported to access amenities in the local community.

We asked how often residents' meetings were held. The registered manager told us that no residents' meetings were held and questioned the value of these. However, we discussed the importance of this and of empowering people to be involved in decisions made at the home. The registered manager was receptive to this and told us they would give this further consideration.

We asked the registered manager how often staff meetings were held. The registered manager told us there had been two senior staff meetings since the registered manager came into post in June 2015. Items for discussion included, for example, the importance of mattress audits, in depth handovers, and good infection control. However, there had been no staff meetings involving care staff, other than seniors. We discussed this with the registered manager who told us they were hoping to introduce staff meetings every three months or six months. This was outlined in the registered manager's action plan.

We found that regular audits took place, for example in relation to care plans, infection control and the environment for example. We saw these resulted in action logs. Actions identified included, 'Slings need washing,' 'Bath chair needs cleaning,' and 'New ironing board cover needed.' However, it was not recorded on the log whether these actions had been completed. It was therefore difficult to determine whether areas which were identified as requiring improvement had been rectified. We highlighted this to the registered manager who told us the actions had been completed but had not been documented.

We looked at different policies and procedures and found they were in place in relation to safeguarding, whistleblowing, accidents and incidents and medication for example. We found, however, that not all policies were up to date. For example, the safeguarding policy was dated September 2014 and this was due to be reviewed by September 2015 but it had not been reviewed. The moving and handling policy had not been reviewed since February 2011. This could mean that the registered manager and staff were not following most recent guidelines. We shared our findings with the registered manager who agreed to address this.

The registered manager showed us records to confirm that, since coming into post, the registered manager had met with 29 out of the 37 members of staff. This was an ongoing action on the registered manager's action plan. The purpose of these meetings was, 'Establishing standards and expectations.' During the meetings, staff were reissued with policies such as equality and diversity, health and safety, whistleblowing and accident reporting for example. This showed the registered manager was taking steps to ensure that staff were clear of their roles and responsibilities.

We saw that quality surveys had been sent to visiting professionals, relatives and friends. The registered manager told us that a resident survey was due to be completed during the month of the inspection. The surveys were

Requires improvement

Is the service well-led?

analysed and action was taken where this was identified. For example, a survey had raised an issue with the laundry service and, as a result, a new labelling system was introduced.

Since coming into post, the registered manager had developed an action plan. They had identified areas which required improvement at the home and had begun to take actions to implement the improvements. The plan included details such as, 'What I am hoping to achieve,' 'How I will achieve it,' and, 'Timescale.' The plan had last been updated on 9 November 2015 and showed details of outstanding actions and completed actions. This showed the registered manager had a clear vision for the home and had developed a plan as to how they intended to achieve improvements. However, there were some areas we identified during the inspection such as developing emergency plans, holding residents' meetings, following best practice guidelines, inconsistencies in the administration of medicines and inconsistencies in care plans that the registered manager had not identified prior to our inspection. This demonstrated a further breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the registered manager had not sufficiently assessed, monitored and improved the quality and safety of the services provided at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not properly and safely managed and staff did not follow policies and procedures in relation to managing medicines. Regulation 12(2)(g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The services provided at the home were not sufficiently assessed and monitored to improve the quality and safety of the services provided. Regulation 17(2)(a). Risks relating to the health, safety and welfare of service users were not assessed, monitored and mitigated. Regulation 17(2)(b).